TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctor's Hospital at Renaissance

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-1171-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $374.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier disagrees with the provider's dispute position."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 22, 2016	96361, 74177, 71260, 36600	$374.12	$54.30

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - OA – The amount adjusted is due to bundling or unbundling of services.

Issues

1. What rule applies to reimbursement?
2. What is the maximum allowable reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement for $374.12 for outpatient hospital codes 96361, 74177, 71260 and 36600 rendered on January 22, 2016.

   The requestor states, "…reimbursement should be $2,832.73." The respondent states, "Carrier's disagrees with the providers dispute position."

   As both positions are related to the appropriate fee, this review will consider the applicable fee guideline found in 28 Texas Administrative Code §134.403, "Hospital Facility Fee Guideline--Outpatient."

   The relevant portions are:

   > (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise
   >
   > > (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.
   >
   > (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > >
   > > > (A) 200 percent; unless
   > >
   > > > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

2. The Medicare payment policies used to calculate the MAR are found at, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used to calculate the Medicare payment for OPPS are found below:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

- **Composite** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

Review of the submitted medical claim finds no request for separate reimbursement of implantables. The services in dispute will be reviewed per 28 Texas Administrative Code § 134.403 (f)(1)(A).

Procedure Code	Status Indicator	APC	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.7989	40% non-labor related	Payment	Maximum allowable reimbursement
96361	S	5691	$30.87	$30.87 x 60% = $18.52	$18.52 x 0.7989 = $14.80	$30.87 x 40% = $12.35	$14.80 + $12.35 = $27.15	$27.15 x 200% = $54.30
36600	Q1	*See below*	n/a					
74177 71260	Q3	8006 *See below*	$493.91	$493.91 x 60% = $296.35	$296.35 x 0.7979 = $236.75	$493.91 x 40% = $197.56	$236.75 + $197.56 = $434.31	$434.31 x 200% = $868.62
						Total		$922.92

Status Indicator **Q1** has the following definition – "STV-Packaged Codes. Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a CHPCS code assigned status indicator "S," "T," or "V." Based on this status indicator code 36600 is not separately payable as submitted code 96361 has a "S" status indicator.

Status indicator **Q3** Codes that may be paid through a composite APC. Paid under OPPS; Addendum B displays APC assignments when codes are paid through a composite APC. Addendum M displays composite assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. The definition of composite 8006 – is "CT and CTA with Contrast Composite - Payment for any combination of designated imaging procedures within the CT and CTA imaging family on the same date of service. If a "without contrast" CT or CTA procedure is performed on the same date of service as a "with contrast" CT or CTA procedure, the IOCE will assign APC 8006 rather than APC 8005."

As codes 74177 is “Computed tomography, abdomen and pelvis; with contrast material(s)” and 71260 is “Computed tomography, thorax; with contrast material(s)”, the services in dispute are subject to the single composite payment for 8006 rather than individual payment.

3. The total allowable reimbursement for the services in dispute is $922.92. Based on the “Electronic Provider Remittance Advice” with payment date April 26, 2016, the insurance carrier paid $561.61 under code 74177 and $307.01 for code 71260 for a total of $868.62. No payment found for code 96361. Therefore, an additional payment of $54.30 is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $54.30.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $54.30, plus applicable accrued interest per 28 Texas Administrative Code §134. due within 30 days of receipt of this Order.

Authorized Signature

		January 27, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.